FACTS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

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HEALTH REFORM AND COMMUNITIES OF COLOR: IMPLICATIONS FOR RACIAL AND ETHNIC HEALTH DISPARITIES

EXECUTIVE SUMMARY

By 2045, more than half of the population in the U.S. will be a person of color. In general, people of color continue to experience worse access to health care and worse health outcomes than their white counterparts. The economic and opportunity costs associated with disparities are shared by everyone through money spent on preventable medical care and lost productivity in the workplace, among other things. The Patient Protection and Affordable Care Act, enacted by Congress and signed by President Obama in March, extends health coverage to many of the millions of individuals who would otherwise remain uninsured, and includes several provisions that will either directly or indirectly impact racial and ethnic health disparities.

People of color have much to gain from health reform. Although they represent one-third of the total U.S. population, they comprise more than 50 percent of the uninsured. People of color are more likely to be low-income than whites, and less likely to have health coverage through an employer, in part because they more likely to be unemployed, and when employed, they are more likely to work low-wage jobs, which are less likely to offer coverage. Many people of color will likely benefit from the expansions to Medicaid and the financial aid being offered to some of the individuals purchasing coverage through the health exchange. This issue brief discusses some of the key provisions of the law that will expand health coverage and are likely to improve access to care for people of color, as well as some of the other provisions that will likely have either a direct or indirect impact on health disparities.

Expanding Health Coverage

Employer Mandate – People of color are more likely to work low-paying jobs, and have decreased access to employer sponsored coverage compared to non-Hispanic whites. The new law, while not mandating employer coverage, does require employers with more than 50 employees to pay a fine if any of their employees receives a premium credit when purchasing health coverage through the newly established health exchange because they were not offered coverage. The employer requirement, along with the premium credits and cost-sharing subsidies would likely allow many people of color to obtain health coverage that would otherwise remain unaffordable.

Health Exchange – The new law allows individuals with incomes above 133% of the federal poverty level (FPL) to purchase coverage through a newly created health exchange if employer sponsored coverage is not available, or if their employer coverage is deemed too expensive for them. To ensure that coverage in the exchange is affordable, premium credits and cost-sharing subsidies will be available to people with incomes up to 400% FPL. Many people of color will be eligible for these premium credits and cost-sharing subsidies, as 4 out of 5 blacks, Hispanics and American Indians and Alaska Natives have incomes below 400% FPL.

Medicaid Expansions – Nearly 6 out of 10 of the 22 million nonelderly uninsured individuals with incomes below 133% FPL are a person of color. The Patient Protection and Affordable Care Act expands Medicaid eligibility to include most individuals with incomes up to 133% FPL, including men and childless adults. The federal poverty level in 2010 is $10,830 for individuals and $22,050 for a family of four.

Improving Access to Care

Community Health Centers – Community health centers fill a critical need for communities of color, as half of the patients who receive care at a community health center are people of color. The new legislation includes funding increases for community health centers, which will help them meet the needs of their patient population.

Workforce Development – Numerous reports indicate the health system is experiencing or will soon experience a shortage of health professionals, particularly among nurses. Many low-income individuals, rural residents, and people of color live in medically underserved areas, where these shortages already exist. The new law contains provisions aimed at increasing the number of providers, particularly in the areas of general medicine, geriatrics, and pediatrics, and increasing the number of providers in medically underserved areas.

Disparities-Specific Provisions

In addition to the other provisions, the health reform law also contains some provisions specific to health disparities. These provisions focus on improving data collection on race, ethnicity, primary language, geographic area, and disability. Other provisions in the proposals address cultural competency training for providers treating the disabled and ensuring information provided to individuals enrolling in Medicaid or purchasing coverage through the exchange is culturally and linguistically appropriate.

Other Provisions Related to Disparities

Indian Health Care Improvement Act – Engrossed into the larger bill, the Indian Health Care Improvement Act was reauthorized for the first time since 2001, and the reauthorization is permanent. This comprehensive bill addresses many of the needs of the American Indian and Alaska Native community, including provisions to improve health promotion and disease prevention services, provisions to improve access to care for urban Indians, and provisions to modernize facilities where American Indians and Alaska Natives receive care.

Immigrants – Legal immigrants will remain eligible for Medicaid, but will continue to be barred from enrolling in Medicaid during their first five years residing in the U.S. Legal immigrants without an offer of credible coverage from their employer, and those with credible coverage through their employer whose premiums exceed a specified percentage of their income will be eligible to receive premium credits and subsidies on the same basis as citizens through the health exchange. The new law does not allow undocumented immigrants to enroll in Medicaid or to receive premiums credits or cost-sharing subsidies for coverage through the health insurance exchange.

Prevention – People of color experience higher rates of many chronic conditions, as well as higher death rates from many of these conditions compared to whites, and the costs associated with these diseases are high. The health reform law contains provisions to improve the overall health of the population through improved access to proven preventive services, including the establishment of a national prevention trust fund. The law also calls on the Secretary of Health to develop the first ever national prevention strategy.

Quality Improvement – While there is still much to be done, overall health care quality is the U.S. is improving, but national trends mask differences by race and ethnicity.[1] The latest *National Healthcare Disparities Report* from the Agency for Healthcare Research and Quality showed that people of color continue to receive worse quality of care for many conditions, even after they are admitted to the hospital. The new law calls on the Secretary of Health to establish the first national quality improvement plan. This plan includes the establishment of national indicators of quality, to be tracked by race and ethnicity among other things.

People of color tend to have higher unemployment rates, lower incomes, and are more likely to be uninsured than non-Hispanic whites. Thus, they have much to gain from the passage of the Patient Protection and Affordable Care Act and the coverage expansions included in the law. People of color also tend to be more reliant on the safety-net for their health care than non-Hispanic whites. As a result, the provisions specific to the safety net and the workforce provisions will likely have a significant impact on access to care for people of color. Much remains to be determined with regards to the implementation of health reform, but with sufficient funding for implementation and oversight, the goals of health reform have a better chance of being met.

BACKGROUND

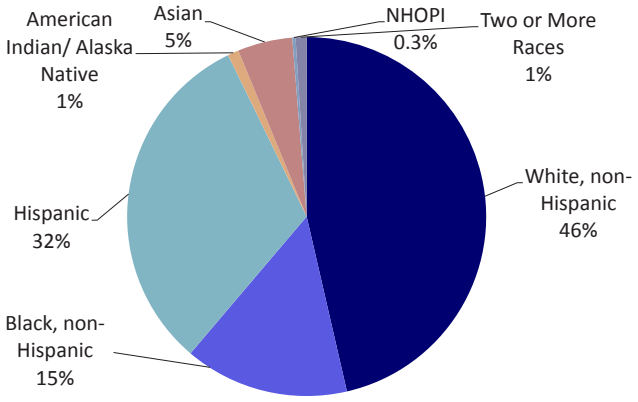
People of color represent a growing proportion of the population in the United States. By 2045, they will account for more than half of the population.[2] In general, people of color tend to have worse access to health care, tend to receive lower quality care when they are able to access it, and tend to have worse health outcomes than non-Hispanic whites. It is hard to know the true cost of health disparities, but a recent report estimated that between 2003 and 2006, more than $200 billion could have been saved in direct medical care expenditures if racial and ethnic health disparities did not exist.[3] The direct and indirect costs attributed to health disparities contribute to the growth of health care costs in national health care expenditures, which is one of the reasons Congress has undertaken health reform.

The Patient Protection and Affordable Care Act enacted by Congress and signed by President builds on the current health care system, but it also makes many significant changes.

One of the main goals of the health reform law is to expand health coverage to many of the more than 45 million nonelderly individuals who currently lack coverage. Other goals of the law include improving the quality of care patients receive, reducing health care costs for the federal government, and expanding the health care workforce. The law also contains a few provisions specific to racial and ethnic health disparities, and there are other provisions not specific to disparities that will likely impact them, such as the coverage expansions. Although people of color represent one-third of the U.S. population, they comprise more than half of the uninsured (Figure 1).

Figure 1

Distribution of Nonelderly Uninsured by Race/Ethnicity, 2008



Total Nonelderly Uninsured Population = 45.7 million

DATA: 2009 March Supplement, Current Population Survey.
SOURCE: Kaiser Family Foundation Analysis

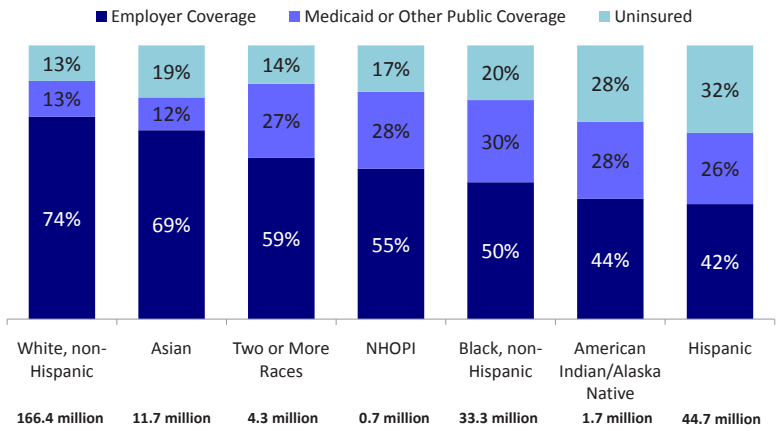
EXPANDING HEALTH COVERAGE

Nationally, nearly 46 million nonelderly individuals were uninsured in 2009. Expanding access to health coverage for many of the uninsured is one of the major goals of the health reform law. People of color have higher uninsured rates than non-Hispanic whites, and Hispanics are the group with the highest uninsured rate (32%). Were it not for public programs such as Medicaid, uninsured rates for all individuals, regardless of race, would be higher. Having health coverage is an important determinant of access to health care. Fewer uninsured individuals have a usual source of care or receive preventive care screenings compared to insured individuals.[4] The uninsured also have more preventable hospitalizations, and ultimately have worse health outcomes than those with insurance.[5]

In the U.S., most individuals have employer sponsored health coverage. However, with the exception of Asians, rates of employer sponsored coverage for people of color are much lower than those of non-Hispanic whites (Figure 2). Building on the current system, the new law will provide coverage to the uninsured through individual and employer mandates, expansions to Medicaid, and the creation of a health insurance exchange where individuals who would otherwise remain uninsured can purchase coverage.

Figure 2

Health Coverage Distribution of the Nonelderly by Race/Ethnicity, 2008



DATA: 2009 March Supplement, Current Population Survey.
SOURCE: Kaiser Family Foundation Analysis

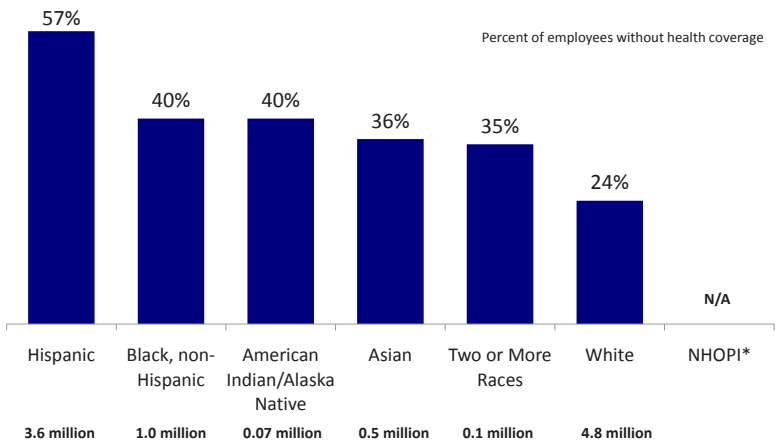
Employer Mandate

People of color are more likely to work low-wage jobs, and have decreased access to employer sponsored coverage compared with whites.[6] Many people of color work for small employers, who compared with their larger counterparts, are less likely to offer health coverage to their employees.[7] For various reasons, however, even among small employers, racial and ethnic disparities exist among those with health coverage (Figure 3). While the new law does not require employers with more than 50 employees to provide coverage, these employers will be required to pay a penalty if they do not offer coverage and one of their employees receives a premium credit while purchasing coverage through the health insurance exchange. For smaller employers, the federal government will provide subsidies and tax credits to help make coverage more affordable. The law allows employees whose coverage premiums exceed 9.5 percent of their income access to premium credits and coverage through the health insurance exchange.

The employer mandate and access to premium credits for low-wage workers and those for whom coverage remains unaffordable will likely lead to coverage expansions for minority workers and their families.

Figure 3

Uninsured Rate for Nonelderly Workers in Small Firms by Race/Ethnicity, 2008



NOTE: Small firms have fewer than 100 employees. *Estimate for Native Hawaiian and Other Pacific Islanders is not reliable due to sample size.
DATA: 2009 March Supplement, Current Population Survey.
SOURCE: Kaiser Family Foundation Analysis

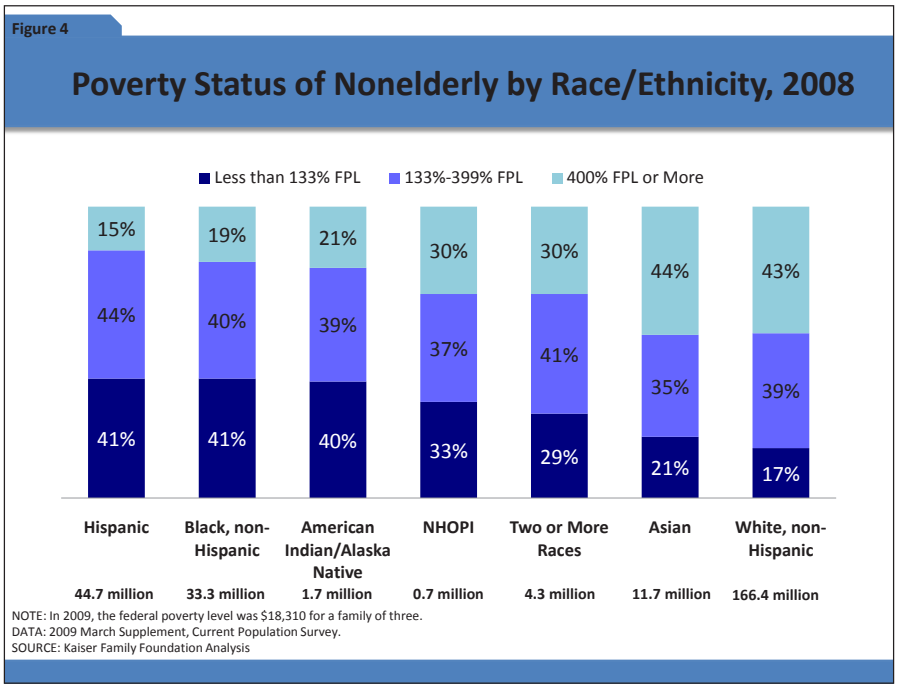
Health Exchange

The Patient Protection and Affordable Care Act expands coverage to the uninsured with incomes above 133% FPL by creating a new marketplace – the health exchange – where they will be able to compare health coverage policies. The law requires the Secretary of Health or an advisory panel to determine which benefits will be required of plans offering coverage through the exchange. Individuals without an offer of credible coverage from their employer, and those for whom their premiums are deemed too costly will be eligible to purchase health coverage through the health exchange.

To ensure that coverage in the health exchange will be affordable, premium credits will be available for many individuals. These premium credits will be available to individuals and families with incomes up to 400% of the federal poverty level. The health reform law also includes subsidies to assist with cost-sharing. Cost-sharing subsidies will be available for individuals and families with incomes up to 400 percent of FPL. These subsidies will help to limit the out-of-pocket expenditures for many individuals and families.

These credits would be particularly important to communities of color, as they comprise 50 percent of the 19 million nonelderly uninsured individuals with incomes between 133% FPL and 399% FPL. Additionally, individuals and families in these communities tend to have fewer economic resources at their disposal to pay for health coverage and out-of-pocket medical expenses. Nearly 4 out of 5 nonelderly blacks, Hispanics, and American Indian and Alaska Natives have incomes below 400% of FPL (Figure 4), and before the start of the recession, there was a six-fold difference between the median net worth for white, non-Hispanic families ($171,200) with holdings compared to families of people of color ($28,300) with holdings.[8] For these individuals in particular, the premium credits and subsidies as well as what the Secretary of Health defines as "affordable" coverage will likely have a significant impact on who is able to purchase health coverage. The timing of the credits and subsidies will also be critical in determining whether an individual is able to afford coverage. The new law ensures that premium credits and cost-sharing subsidies are available to individuals and families at the time they purchase their health coverage. This will be important for many people of color, who, due to wealth differences between them and non-Hispanic whites, will likely have difficulty affording the up-front expenditures associated with purchasing health coverage without subsidies at the time of purchase.

Figure 4

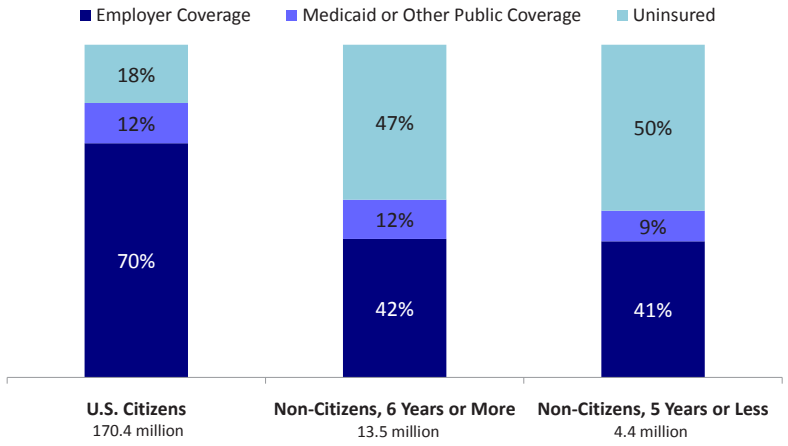


Despite the efforts to limit cost sharing, affordability of health coverage is likely to remain an issue for some individuals, particularly the sick. For some individuals, the total cost of premiums, coinsurance, and the maximum amount cost-sharing might mean that they would still spend a significant amount of their income on health expenditures.

Nearly 40 million individuals residing in the U.S. are immigrants.[9] More than one-third (36%) of them have become naturalized citizens, another third (34%) are legal immigrants, and the remaining 30% (11.9 million) are estimated to be undocumented. Among nonelderly adults, non-citizens (including legal and undocumented immigrants) have a significantly higher uninsured rate compared to citizens, regardless of how long they have resided in the U.S., and despite similar employment levels, non-citizens have much lower rates of employer coverage than citizens (Figure 5). Coverage rates are similar for all nonelderly non-citizens who have been in the U.S. for 5 years or less and those who have been in the U.S. for 6 years or more, and are largely a result of Medicaid coverage rates among children. Under the new law, legal immigrants without an offer of credible coverage from their employer, and those with credible coverage through their employer whose premiums exceed 9.5 percent of their income would be eligible to receive premium credits and subsidies on the same basis as citizens. The new law would not allow undocumented immigrants to receive premiums credits or cost-sharing subsidies.

Figure 5

Health Coverage Distribution of Nonelderly Adults by Citizenship, 2008



DATA: 2009 March Supplement, Current Population Survey.
SOURCE: Kaiser Family Foundation Analysis

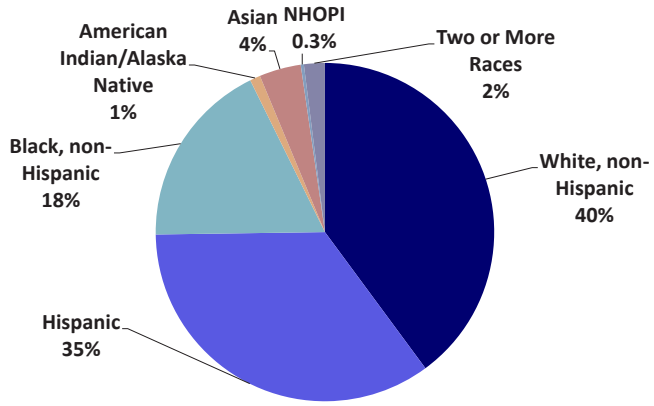
Medicaid Expansions

The Patient Protection and Affordable Care Act includes a significant expansion of Medicaid. Under the law, all individuals, regardless of age, sex or parental status, will be eligible for Medicaid if they meet the income threshold. Individuals with incomes below 133% FPL (the current poverty level is $10,830 for an individual and $22,050 for a family of four) will be eligible to receive Medicaid services.

Of the 65 million nonelderly individuals with incomes below 133% FPL, over 22 million are uninsured, and nearly 6 in 10 are people of color (Figure 6). Some of these individuals are currently eligible for Medicaid, but for various reasons, are not enrolled. Gender differences also exist among the uninsured, with men having a higher uninsured rate than women. This is largely the result of fewer men previously being eligible to receive coverage through Medicaid, which typically provides coverage to low-income pregnant women, low-income adults with dependent children and the disabled, and tends to exclude childless adults. Moreover, the income threshold by which low-income adults qualify for Medicaid in most states is significantly lower than the threshold for children and pregnant women. As a result of the changes in the new law, more poor people will be eligible to receive health coverage through Medicaid, and poor men and poor women who meet the income threshold would have equal access to coverage through Medicaid, regardless of their parental status.

Figure 6

Distribution of Nonelderly Uninsured Below 133% FPL by Race/Ethnicity, 2008



Total Nonelderly Uninsured Below 133% FPL = 22.1 million

NOTE: In 2009, the federal poverty level was $18,310 for a family of three.
DATA: 2009 March Supplement, Current Population Survey.
SOURCE: Kaiser Family Foundation Analysis

Increasing the Medicaid eligibility to 133% has the potential to significantly reduce the number of uninsured. The Congressional Budget Office estimates that raising the eligibility level to 133% would lead to 16 million new people receiving coverage through Medicaid and CHIP over the course of the next 10 years.[10] How many newly eligible individuals actually enroll in Medicaid will depend on the extent to which states simplify the enrollment process, educate eligible individuals about their options, and coordinate with the exchanges in creating "no wrong door." Lessons from Medicaid and CHIP enrollment processes indicate that the process should be as simple as possible, and there should be coordination between the necessary agencies to help streamline the process and reduce delays.

The health reform law does not allow undocumented immigrants to qualify for Medicaid. Legal immigrants will remain eligible for Medicaid, but most legal immigrants would continue to be barred from enrolling in Medicaid during their first five years residing in the U.S., although states now have the option to vacate this waiting period for otherwise eligible children and pregnant women.

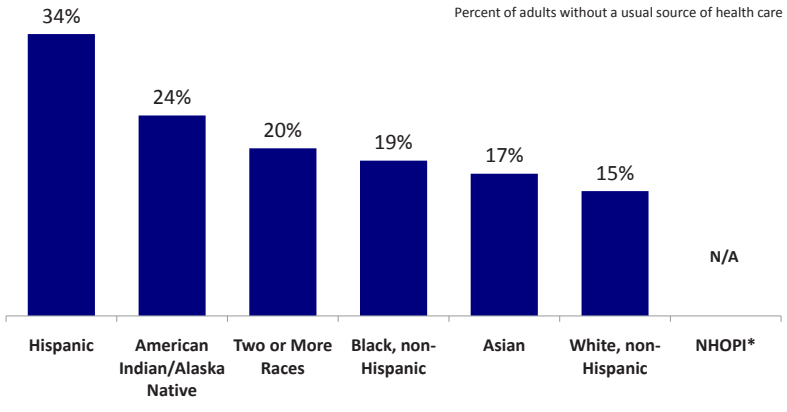
While Medicaid enrollees have better access to care compared to the uninsured, problems finding physicians exist in the program. Participation among providers has typically been low, which has been attributed in part to the payment rates.[11] Payments to Medicaid providers have traditionally been lower than those of Medicare and private coverage. On average, for every dollar Medicare paid a provider, Medicaid as paid $0.72, and payment rates have varied substantially by state and for a given category of services (e.g. primary care vs. obstetric care).[12] The new health reform law includes an increase in Medicaid payments for primary care for 2013 and 2014, but this increase is not permanent. In the absence of an increase in the number of providers willing to treat patients with Medicaid coverage and an increase in the number of providers in medically underserved areas, the significant expansion of the program in the new health reform law could exacerbate existing access problems, as well as lead to a worsening of health disparities. The new law includes several provisions that seek to address these workforce issues.

IMPROVING ACCESS TO CARE

Having insurance is critical to receiving timely health care. However, having health coverage is not enough to guarantee access to care. A common measure of access to care is whether an individual has a usual source of care. More people of color report not having a usual source of care and not having a personal health care provider than whites (Figure 7).[13] Furthermore, prior to the passage of health reform, numerous reports indicated there will be a shortage of available health care professionals (e.g. doctors, nurses, dentists, and pharmacists) in the very near future, and that some areas such as nursing, pharmacy and public health are already experiencing a moderate shortage.[14] To address these issues, the new law includes provisions to increase the health care workforce, and strengthen community health centers, which provide a substantial amount of care to people of color and low-income individuals.

Figure 7

Percent of Nonelderly Adults with No Usual Source of Care by Race/Ethnicity, 2008



NOTE: * Estimate for Native Hawaiians and Other Pacific Islanders is not reliable due to small sample size.
SOURCE: Table 76. No usual source of health care among adults ages 18-64 years of age, by selected characteristics. United States, average annual selected years 1993-1994 and 2006-2007. *Health US, 2009.* National Center for Health Statistics. Hyattsville, MD: 2010.

Community Health Centers

By law, community health centers must be located in, medically underserved communities or communities that are designated primary care health professional shortage areas (HPSA), or they must have as their target population communities that experience these circumstances. Community health centers play a critical role in providing care to people of color. Although people of color represent one-third of the U.S. population, half of the patients who receive care in community health centers are a person of color.[15] Community health centers also play a critical role in the provision of care to migrant workers.

Under the new health reform law, community health centers will receive a boost in funding. Community health centers would also receive a special payment from Medicaid. They would also receive an increased reimbursement rate from Medicare, which has typically under reimbursed community health centers for their services. The law also creates teaching health centers and provides grants to establish nurse-managed health centers to increase the provision comprehensive primary care services and wellness services. Finally, the new law requires the Secretary of Health to re-evaluate the definition of medically underserved areas (MUA) and health professional shortage areas. Nearly 3 in 10 nonelderly persons of color lives in a primary care HPSA, and many more live in areas that lack enough mental health providers.[16]

Workforce Development

The health reform law contains several provisions aimed at increasing the number of primary care providers, nurses, and public health workers, including public health dentists and dental hygienists. This would be accomplished largely through loan repayment programs, training grants, and expansions in the National Health Service Corps Program.

The new law also includes provisions to try to increase the number of providers in primary care, pediatrics, and geriatrics, and although there is a reallocation of unused residency positions and an increase in payments to primary care providers in underserved areas, there is not much else that addresses the unequal distribution of providers that has left many people living in a primary care or mental health professional shortage area. Many low-income individuals, rural residents, and people of color live in medically underserved areas. Training programs will take many years to increase the primary care and public health workforce, but the need for these providers will be more immediate. These workforce expansions could provide much needed help to these communities, but it is likely that additional efforts will be needed to adequately address both the current health professional shortage, and the increased demand for services resulting from the newly insured individuals.

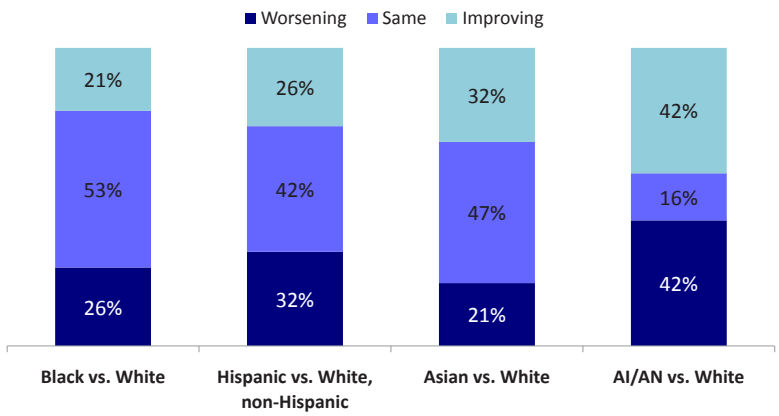
DISPARITIES-SPECIFIC PROVISIONS

The disparities-specific provisions of the Patient Protection Affordable Care Act largely focus on improving upon our ability to document disparities in health and health care. The new health reform law also includes provisions to increase collection and reporting of data on race, ethnicity, and language, and requires the establishment of uniform categories to be used in the collection of race, ethnicity, sex, and primary language for federally-funded health care and health-related activities. This is timely, given the recent recommendations from the Institute of Medicine's (IOM) *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* report. In it, the IOM recommended the collection of race and ethnicity using the Office of Management and Budget's recommended race and Hispanic ethnicity categories, collecting granular ethnicity data with categories specified by Health and Human Services (HHS), and collecting data on spoken language, including English proficiency and preferred language for medical encounters, using a standard set of categories provided by HHS. The IOM also encouraged the collection of data on language preference for written materials where possible. In addition to requiring data collection using standardized categories, the new law would requires that, to the extent practical, all federally-funded population surveys to collect enough data to allow for reliable reporting of racial and ethnic subgroups. These provisions would greatly improve the ability to document disparities, especially among some of the smaller populations who are typically either excluded from the reporting of survey findings, or grouped as "Other."

While data collection is necessary to document the extent of the problem and to measure progress in remedying the situation, elimination of the problem does not necessarily follow. Evidence of this can be found in the *National Healthcare Disparities Report* (NHDR). Mandated by Congress in the Minority Health and Health Disparities Research and Education Act of 2000, the Agency for Healthcare Research and Quality has produced the NHDR every year since 2003. Yet, as the latest report shows, gaps in health care quality between whites and people of color remain unchanged, and in some cases are getting wider (Figure 8).[17]

Figure 8

Changes Over Time in Quality of Care Disparities by Race/Ethnicity, 2000-2002 to 2005-2007



NOTES: "Improving" means disparity is becoming smaller over time; "worsening" means disparity is becoming larger over time. Data on all measures are not available for all groups. Totals may not add to 100% due to rounding. Time period differs by measure and includes oldest and newest years of available data.
SOURCE: Figure H.3. Distribution of changes over time in racial, ethnic, and socioeconomic disparities for selected core quality measures, 2000-2002 to 2005-2007. *National Healthcare Disparities Report, 2009*. Agency for Healthcare Research and Quality

OTHER PROVISIONS RELATED TO RACIAL AND ETHNIC HEALTH DISPARITIES

American Indians and Alaska Natives

American Indians and Alaska Natives experience some of the worst health outcomes and have some of the worst access to care of all racial and ethnic populations in the U.S. American Indian and Alaska Native women have some of the highest rates of diabetes, heart disease, and serious psychological distress.[18] Similar to blacks and Hispanics, 1 in 3 nonelderly American Indians and Alaska Natives live in poverty, and the uninsured rate for nonelderly American Indians and Alaska Natives is the second highest of any racial or ethnic group in the U.S. at 28 percent. Many American Indians and Alaska Natives access care through the Indian Health Service, which, as a result of chronic underfunding, rations care based on a hierarchy of need.

The Patient Protection and Affordable Care Act exempts American Indians and Alaska Natives from paying a penalty for not having health coverage. It also exempts tribal benefits from gross income calculations, and prohibits cost-sharing for American Indians and Alaska Natives with incomes below 300 percent of the federal poverty level (FPL). Many American Indians and Alaska Natives are low-income (4 in 10 below 133% FPL), and therefore would meet the income threshold to qualify for Medicaid. In the absence of a financial penalty, it is unclear how many American Indians and Alaska Natives would obtain coverage. For American Indians and Alaska Native currently receiving care through the Indian Health Service who either enroll in Medicaid or in a health care plan through the health exchange, the additional income to clinics through a third party may help ease some of their financial strain, thereby leading to a decrease in the rationing of health care at these facilities, and an increase in the number of people receiving needed care in a timely manner.

The law also contains all of the provisions of the Indian Health Care Improvement Act of 2009 (IHCIA). The IHCIA is a comprehensive bill aimed at addressing the myriad of health and access needs of the American Indian and Alaska Native population. Included in the IHCIA are provisions to increase the number of American Indian and Alaska Native health providers, provisions to increase and improve health promotion and disease prevention services, provisions to improve availability of behavioral health services, and provisions to improve access to care for urban Indians. There are also provisions to renovate health care facilities serving large populations of American Indians and Alaska Natives. The law includes provisions to strengthen payments to providers treating American Indians and Alaska Natives, regardless of the location of services, and provisions to increase outreach and streamline the enrollment of eligible American Indians and Alaska Natives into CHIP and Medicaid.

Prevention

Primary and secondary prevention are important parts of maintaining a healthy population. People of color experience higher rates of diabetes, hypertension, obesity and asthma, and have higher death rates from heart disease than whites.[19] The evidence linking obesity to other health problems continues to mount, and direct medical costs for diabetes and heart disease were estimated to be more than $100 billion and $300 billion, respectively.[20]

The Patient Protection and Affordable Care Act contains several provisions for prevention and wellness, including a provision to develop a national strategy for improving the nation's health through preventive efforts, and the establishment of an investment fund to help further prevention and public health programs. The law also awards grants to state, local and community-based organizations to implement efforts to reduce chronic disease rates and health disparities.

The law would cover "proven" preventive services for Medicare and Medicaid enrollees, and require new private insurance plans to do the same. Recent regulations issued by the Departments of Health and Human Services, Treasury, and Labor require private health plans to cover, without cost-sharing, preventive services with either a Grade A or B recommendation from the U.S. Preventive Services Task Force, immunizations with a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and preventive care and screenings for women, infants, children, and adolescents from the comprehensive guidelines supported by the Health Resources Services Administration (HRSA).[21]

The new health reform law also allows employers to offer financial rewards to employees participating in wellness programs. These rewards would cover up to 30 percent of the cost of coverage.

Demonstration Projects – The Patient Protection and Affordable Care Act calls for demonstrations projects across a variety of areas. Some of these projects will research the use of health homes (a.k.a. medical homes) for individuals with chronic conditions, the use of dental sealants in children, efforts to reduce teen pregnancy, the possibility of using community grants to improve the health of the overall community, and research the increased use of school-based health clinics, among other things. Among the criteria for awarding many of these contracts are an organization's history of working in underserved communities, and history of programs aimed at reducing racial and ethnic health disparities. These demonstration projects have the potential to expand our knowledge of efforts to reduce racial and ethnic health disparities.

CONCLUSION

The Patient Protection and Affordable Care Act contains many provisions that will likely impact the health of and health care received by people of color. Chief among them are the expansions in coverage, since people of color are disproportionately represented among the uninsured. While the coverage expansions promulgated by the health reform law will not be sufficient to eliminate health disparities, they are a necessary first step.

Like the expansions in health coverage, the disparities-specific provisions in the new law serve as an important step in addressing racial and ethnic health disparities. There are many factors within the health care system that contribute to health disparities including health coverage, patient behavior and provider quality. However, the racial and ethnic disparities evident in the health care system today are influenced by a myriad of factors that reside outside of the traditional health care system such as poverty, stress, social support, health literacy and the environment, and many of these factors were not addressed in the new health reform law.

Some of the provisions pertinent to racial and ethnic health disparities included in the health reform law rely on grants and demonstration projects. Due to fiscal constraints, it is likely that many people will be left out of the grantmaking process. Demonstration projects are helpful to gather knowledge where little exists, but unless the successful findings are incorporated into existing programs and unless new programs are generated to put the knowledge of what works into practice, it is unlikely that these projects will contribute as much as they could towards the reduction in racial and ethnic health disparities.

Much remains to be seen regarding the implementation of the premium credit and cost-sharing subsidies, and the benefit design of health plans within the exchange. Many of the rules and regulations regarding implementation have yet to be written. Funding levels for many demonstration projects and appropriations for the Indian Health Care Improvement Act have yet to be determined. With sufficient funding, the agencies and organizations tasked with the implementation and oversight of health reform will be more able to complete their tasks, and the aims of the Patient Protection and Affordable Care Act will have a greater probability of being achieved. Regardless, the coverage expansions, particularly to low-income individuals through Medicaid, and the premium credits and cost-sharing subsidies aimed at making coverage more affordable, will greatly benefit communities of color, and may lead to reductions in racial and ethnic disparities in health and health care.

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